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ABSTRACT

Considered are the needs of the aged mentally retarded as related to trends toward the deinstitutionalization of retarded persons into the community. (DB)

PEOPLE WHO NEED PEOPLE

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PEOPLE WHO NEED PEOPLE

The social problem of aging is enjoying an increase in national attention (Morris and Randall, 1965, pp. 96-103). A group which has received considerably less attention is the geriatric mental retardate.

For many years mental retardation was thought to be one of custodial care. Large and isolated custodial institutions for the mentally retarded were created to remove them from the complexities of the modern, urbanized and industrialized environment (Wolfensberger, 1969, pp. 94-100). The expectation was that once a retardate was institutionalized, he was there indefinitely (Katz, 1968). Hence, institutionally, he would be taken care of. The greater understanding of mental retardation, in recent years and the current emphasis on the educational, medical, and social needs of this group of people has led to expanded efforts to create alternate living arrangements to the isolated institution. The purpose of these services is to maintain the elderly mentally retarded within the community setting.

The shifting of direction toward community living has been influenced in two ways: (a) the fact that the aged constitute only a small proportion of the total institutionalized mentally retarded population and (b) the trend toward institutionalizing the younger and more severe population (Tarjam, Eyman, and Dingman, 1966). The efforts to return individuals to the community as well as preventing inappropriate institutionalization is documented--the goals and objectives of many state mental

health and retardation departments. The Executive Order, signed by President Nixon on March 28, 1974 and sent to members of the President's Committee on Mental Retardation, assigned the Committee with "Returning to the community one-third of the persons now in public institutions" (PCMR, 1974).

At present the institution is regarded as not the only place or the best place to deal with the aged mental retardate. The emphasis on de-institutionalization and the recognition of the ability of the retardate to gain from community living has brought about reduction in size of public institutions and growing Federal support for programs and services for de-institutionalization (Kriger, 1975).

If one considers trends, there will be greater reliance on the community in the future. Thus, the de-institutionalized retardate and the retardate who is older but is in the community seems to share the same fate as that of the aging older normal individual (Kriger, 1975).

There have been few studies of the functioning of community-based services for the retarded because the efforts to create effective half-way houses, hostels, and group homes on a large scale are very recent. Lacking supportive services and individualized goals to increase the independence of the residents, the board-and-care facilities are in the community but do not utilize it for programs in vocational rehabilitation or recreation (Edgerton, 1974). Links within the community need to be both strong and numerous in order that there should not develop in the minds of the local population that the aged retardates are an isolated group. It should be assumed that some will work in town (Heath, 1971). Talkington and Chiovaro (1969) established a pilot program for 105 mentally retarded adults 50-72 years of age. It was a well-organized rehabilitation program with positive growth in the area of independence

and direction in life. Salter and Salter (1974) established a program of Reality Orientation, Activities of Daily Living and Recreation Activities, together with environmental stimulation and succeeded in patients' talking, walking, and interest in daily necessities so that they could go to alternate placements. Dr. Kriger (1975) notes "that the centrality of the caretaker is a very important consideration". It is this person, be it relative, or home operator, who is responsible for meeting the daily needs of the aging retardate. For this reason we should make certain through a selection process and training program that these most important people to the retardate have the characteristics deemed necessary and the skills needed. There should be mutual planning between retardate and caretaker to insure a successful program.

There is a growing concern for the aged retardate in knowing that the quality of life is low for the normal older person. Reports of reduced income, lonely mealtimes, poor nutrition, poor housing, etc., constitute conditions that can be anticipated for the retardate.

From the point of view of care and nutrition some pertinent points can be set forth. The older retardate should participate in meal preparation. They should do buying, cooking, and serving as part of the plan. Dining should be "family style" with small tables, choice of foods, and all you can eat. The aging retardates need to have balanced diets and good food. Nutritionist services should be available to home operators or care takers for consultation (Kriger, 1975).

A number of humanistic questions arise. The issue of deinstitutionalization of the mentally retarded to community settings questions what is society doing to help the older retarded and his family? Who are the older retarded? Where are they? What are they doing? What kinds of social skills are needed to live in different residential settings?

People do need people, and I urge concern for the human needs of the aged mentally retarded.

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